410-1
The county department shall complete the determination of eligibility and share of cost as quickly as possible but not later than any of the following:

(1) Forty-five days following the date the application, reapplication or request for restoration is filed.

(2) Ninety days following the date the application, reapplication or request for restoration is filed when the eligibility depends on establishing disability or blindness.

(b) The 45- or 90-day periods may be extended for any of the following reasons:

(1) The applicant, guardian, or other person acting on the applicant's behalf has, for good cause, been unable to return the completed Statement of Facts, Supplement to Statement of Facts for Retroactive Coverage/Restoration or necessary verification in time for the county department to meet the promptness requirements.

(2) There has been a delay in the receipt of reports and information necessary to determine eligibility and the delay is beyond the control of either the applicant or the county department.

(§50177(a))

410-1A
The County Welfare Department (CWD) is required to forward a DED (now the DAPD) referral packet to DED no later than ten days after receipt of the Statement of Facts or other statement of disability is received, except in the event of a delay due to circumstances beyond the control of the CWD. (All-County Welfare Directors Letter No. 93-50, July 23, 1993; *Radcliffe* v. *Cahill*, Stipulation for Entry of Judgment and Order, Case No. 910804, April 23, 1993, San Francisco County Superior Court)

410-1C
When an applicant has excess resources, counties must still complete eligibility determinations within the time limits set forth in §50177. If the applicant provides verification at a later date that excess property was spent on qualified medical expenses (up to three years from the date of the Notice of Action denying benefits), the county must rescind the denial if the applicant is otherwise eligible.

When billing may occur more than one year beyond the date of the service, the county shall complete and send a letter of authorization (MC 180) following the procedures in Medi-Cal Eligibility Procedures Manual §14E and §50746, and shall indicate that eligibility is granted as a result of court order (*Principe* v. *Belshé*).

(All-County Welfare Directors Letter No. 97-41, October 24, 1997)

410-2
The applicant or spouse of the applicant shall complete and sign the Statement of Facts, unless:

(1) The applicant is a child, unless there is no parent, caretaker relative, or other person or agency with legal responsibility for the child; or unless the child is applying for minor consent services.

(2) The applicant has a conservator, guardian or executor.

(3) The applicant is incompetent, in a comatose condition or suffering from amnesia and there is no spouse, conservator, guardian or executor. In this case:

(A) The county department shall evaluate the applicant's circumstances and determine whether or not there is a need for protective services.

(B) The Statement of Facts may be completed and signed on the applicant's behalf by a relative, a person who has knowledge of the applicant's circumstances, or a representative of a public agency or the county department.

(C) The person completing the Statement of Facts on behalf of the applicant shall provide all available information required on the Statement of Facts regarding the applicant's circumstances.

(D) If a county department representative completes and signs the Statement of Facts, another representative of the county department shall confirm, by personal contact, the applicant's inability to act on his own behalf and countersign and approve any recommendations for eligibility.

(§50163(a))

410-2A
An "applicant" is defined as the individual or family making, or on whose behalf is made, an application, request for restoration of aid, or reapplication. (§50021)

410-2B
"Competent" is defined as being able to act on one's behalf in business and personal matters. (§50032)

410-2C
In general, a Medi-Cal application is defined as a written request for aid. (§50022)

However, if a request for a Medi-Cal application is made by phone, the county shall complete a SAWS 1 (i.e., an application form) on the applicant's behalf to protect the applicant's date of application and retroactive months of eligibility, and shall mail the MC 210/SAWS 2 (i.e., a complete application form) to the applicant for completion. (All-County Welfare Directors Letter No. 00-31, May 22, 2000)

410-2D
The CDHS has made available copies of the Medi-Cal form 210, as revised August 2001, in the following languages: Spanish, Vietnamese, Khmer, Hmong, Armenian, Chinese, Korean, Russian, Farsi, and Lao. These copies are available as of January 2, 2002, although the Spanish version has been available since September 2001. (All-County Welfare Directors Letter No. 01-68, December 17, 2001)

410-3
A face-to-face interview with the Medi-Cal applicant or the person completing the Statement of Facts is required only at the time of application, reapplication, redetermination of eligibility or restoration. (§50157(a))

Effective July 1, 1999 beneficiaries are no longer required to attend a face-to-face interview at annual redetermination. Any beneficiary may request a face-to-face interview, but eligibility staff may request such a redetermination interview only for good cause, such as suspicion of fraud. (All-County Welfare Directors Letter (ACWDL) No. 99-36, July 16, 1999)

As of March 24, 2000, a face-to-face interview is not required when adding adults or children over age 19 to the MFBU. The counties shall mail the appropriate forms to the beneficiary, and shall accept photocopies of required documents. Applicants may still request a face-to-face interview, and counties may require these interviews “only for good cause or suspicion of fraud." (ACWDL No. 00-17, March 24, 2000) The mandatory interview was eliminated effective July 1, 2000. (ACWDL No. 00-31, May 8, 2000)

410-3A
Effective July 1, 2000 the CDHS must eliminate the mandatory Medi-Cal face-to-face interview requirement for all persons or families applying for Medi-Cal. Applicants do have the right to request a face-to-face interview with eligibility staff if they so desire.

Eligibility staff are allowed to request the applicant to complete a face-to-face interview only for good cause or suspicion of fraud. Situations which may result in a request for an interview include questionable information on the application form or verifications provided; individual/family has no visible means of support or means of support is not reported; obvious discrepancies exist between information on the application and the Income and Eligibility System’s records of assets or income; or self-employed person whose income and expenses do not match reported income, and questionable information could not be resolved by telephone contact and/or mail.

(All-County Welfare Directors Letter No. 00-31, May 8, 2000)

410-3B
A "beneficiary" means a person who has been determined to be eligible for Medi-Cal. (§50024)

410-4
An applicant may request a withdrawal of an application or request discontinuance from Medi-Cal. This request is to be made in writing. The applicant or beneficiary will also be considered to have withdrawn an application or to have requested discontinuance if he

or she fails to respond to a notice of action which requests that the beneficiary contact the county to indicate a desire to continue eligibility. (§50155)

410-5
Any person who wishes to receive Medi-Cal can file an application; or, when the applicant is unable to apply on his/her own behalf, the application may be filed by the guardian, conservator or executor; by a person who knows of the applicant's need to apply; or by a public agency representative. (§50143(a))

410-6
The county department shall receive and act upon all applications, reapplications, requests for restoration and redeterminations without delay. Any person who wishes to receive Medi-Cal is entitled to file an application. When the applicant is incapable of acting on his/her own behalf or is deceased, the applicant's guardian, conservator or executor, or a public agency representative, or any person who knows of the applicant's need to apply may file the application. (§§50141 and 50143)

410-7
All information provided in the application with the exception of those items which must be verified shall be accepted as a basis for a determination of eligibility and share of cost unless the application is unclear or inconsistent. If additional clarification is needed, the county department shall inform the person who signed the application of the information needed and the reason for the request. Such person shall be responsible for securing the additional information. If the person who signed the application has difficulty in securing the necessary information, the county shall, with the person's written consent, obtain the information. (§50171)

410-8
The County Welfare Department in each county shall be the agency responsible for local administration of the Medi-Cal program under the direction of the CDHS. (§50004(c))

410-9
The 9th Circuit Court of Appeals has determined that when a County Welfare Department is closed on a normal working day, it cannot frustrate the individual's right to file an application on such working day. The Court of Appeals remanded the matter to the Federal District Court to fashion an order which would cure this problem in the AFDC, FS, and Medi-Cal programs by having:

(1) The county offices receive applications during conventional office hours; or

(2) The county offices provide that if they are closed during such hours any application made on the next day they are open filed as if the application had been filed during the hours they were closed.

Since the second solution could not provide AFDC to a family in an emergency situation, the welfare office, if closed on a normal working day, must have a telephone available to review emergency calls and act upon them as if the calls were made on a regular working day. (*Blanco* v. *Anderson and Belshé* (1994) 39 F. 3d 969)

410-9A
After a remand from the Ninth Circuit Court of Appeal, the United States District Court, E.D. Cal, issued its mandate in *Blanco* v. *Anderson*, No. CIV-S-93-859 WBS JFM, December 20, 1994.

That Order dealt with those counties which are closed during normal working days, defined by the Order as eight-hour days, Mondays through Fridays, "excluding federal and state holidays". (Per All-County Letter (ACL) No. 95-08, February 16, 1995, all counties were to document current days and hours of operation by March 3, 1995.)

When a county was part of this class, it was required to:

1. Accept and act on all request for emergency AFDC, FS, and Medi-Cal benefits (including acting on such requests within federal and state time limits) by maintaining sufficient staff in the office, or through local telephone service, to act on these requests; and/or

2. Make applications for AFDC, FS, and Medi-Cal benefits readily available by providing a drop-box, mail slot, or other reasonable filing method, and deem such applications as filed on the working day prior to the day the office was closed.

Such counties must also prominently post notices at the welfare offices explaining the procedures they are following, and inform telephone callers to the office of such procedures.

Any alternative method of complying with the Order must meet the intent of the Order and be reported to CDSS and/or CDHS. (All-County Letter (ACL) No. 94-108, December 15, 1994)

410-10
It is the position of the CDHS that Medi-Cal benefits must continue for any beneficiary (but not for Medi-Cal applicants) who is terminated from Title II and/or SSI/SSP disability benefits due to cessation of disability and who appeals that termination. The continuation of Medi-Cal benefits includes the 65-day period following the Title II and/or SSI notice of planned action, or the latest Title II and/or SSI/SSP appeal decision, if unfavorable, in order to allow the individual to file the next level of appeal (even if an appeal is not filed).

Due to the numerous levels of appeals and extensive backlogs in SSA hearings, beneficiaries could receive Medi-Cal for several years before a final decision is rendered. "A decision becomes 'FINAL' when the beneficiary does not or cannot appeal the termination of Title II or SSI/SSP disability benefits any further. Medi-Cal benefits will continue through the 65-day period following the denial of an appeal in which the next level of appeal can be filed."

(All-County Welfare Directors Letter No. 97-28, June 23, 1997, p. 5)

410-11
Former SSI/SSP recipients who receive AFDC/TANF while their SSI appeals are pending do not lose their rights to continued SSI-based benefits at zero SOC after AFDC/TANF benefits terminate. Until a "final" decision is rendered on the SSI appeal,

those individuals are eligible for zero SOC Medi-Cal, unless the county determines those individuals are ineligible for Medi-Cal.

Those former disabled SSI/SSP recipients appealing the loss of federal disability benefits are considered public assistance (PA) beneficiaries for Medi-Cal purposes until the SSI appeal is resolved, or those individuals do not appeal their SSI decisions.

(All-County Welfare Directors Letter No. 97-28, June 23, 1997, pp. 5-7)

410-12
Due to a federal interpretation, the process for determining Medi-Cal eligibility of "no longer disabled" former SSI/SSP recipients will not be referred to as an "application process", but a "redetermination". "Similar to the *Edwards* lawsuit for the AFDC cases, Medi-Cal benefits must continue at zero share of cost for persons losing SSI/SSP disability cash benefits due to cessation of disability while eligibility is redetermined under Medi-Cal rules." (All-County Welfare Directors Letter No. 97-28, June 23, 1997, p. 8)

410-13
The county of responsibility for determining Medi-Cal eligibility for persons whose eligibility is not determined as part of a family, nor is eligibility based on family income, shall be the county in which the person's home is located if the person is temporarily absent, or the county is which the person is living in all other situations. (§50125)

410-13A
The county in which a person applies for Medi-Cal shall accept the application and statement of fact from such person on behalf of the county of responsibility. The information shall be forwarded to the county of responsibility no later than 15 days from the date of application. The county in which the person applies may, with the consent of the applicant or beneficiary, become the county of responsibility for determining initial eligibility and initiating an intercounty transfer. (§50135)

410-14
County welfare departments (CWDs) must outstation eligibility workers (EWs) at Disproportionate Share Hospitals and Federally Qualified Health Centers unless the CWD can demonstrate that it is not feasible to do so. The CWDs are required to submit new petitions only for the sites which have not participated in the outstationing program in the past, and which presently meet the requirements for outstationing under the Omnibus Budget Reconciliation Act of 1990 (OBRA '90).

The original intent of outstationing still remains to make quick determinations of Medi-Cal eligibility for pregnant women and children.

(All-County Welfare Directors Letter No. 98-13, March 3, 1998, referencing OBRA '90)

410-15
Following approval of Medi-Cal after a *Principe* v. *Belshé*, spenddown, the county and applicant complete form MC 174. The county determines, in consultation with the applicant, whether any of the remaining medical bills paid by the applicant are to be applied to shares of cost for months during the application process. If not, or if only

some of the remaining medical bills will be applied to the shares of cost, then the county shall provide the following information on the Notice of Action approving benefits:

> "IMPORTANT INFORMATION ABOUT GETTING REFUNDS FROM YOUR PROVIDER: State law says that your provider has to give you back whatever you paid for a medical service if that provider gets money from Medi-Cal for the same service. Your provider cannot give you money back if you paid a medical bill with excess property to get below the property limit or if the money was part of your share of cost. Your MC 174 tells you about refunds. If you need another copy of your MC 174, ask your eligibility worker."

(All-County Welfare Directors Letter No. 97-41, October 24, 1997)

410-16
The CDHS shall prepare a simple, clear, consumer-friendly notice, which shall be used by the counties in order to inform Medi-Cal beneficiaries whose eligibility for cash aid under Chapter 2 (commencing with W&IC §11200) has ended, but whose eligibility for benefits under W&IC §14005.30 continues pursuant to W&IC §14005.31(a), that their benefits will continue. To the extent feasible, the notice shall be sent out at the same time as the notice of discontinuation of cash aid, and shall include all the following:

(1) A statement that Medi-Cal benefits will continue even though cash aid under the CalWORKs program has been terminated.

(2) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in existence for receipt of cash aid under the CalWORKs program.

(3) A statement that the Medi-Cal beneficiary does not need to fill out monthly or quarterly status reports in order to remain eligible for Medi-Cal, but shall be required to submit an annual reaffirmation form. The notice shall remind individuals whose cash aid ended under the CalWORKs program as a result of not submitting a status report that they should review their circumstances to determine if changes have occurred that should be reported to the Medi-Cal eligibility worker.

(4) A statement describing the responsibility of the Medi-Cal beneficiary to report to the county, within 10 days, significant changes that may affect eligibility.

(5) A telephone number to call for more information.

(6) A statement that the Medi-Cal beneficiary's eligibility worker will not change, or, if the case has been reassigned, the new worker's name, address, and telephone number, and the hours during which the county's eligibility workers can be contacted.

(W&IC §14005.31(b), to be implemented on or before July 1, 2001, per W&IC §14005.31(c))

410-17
State law provides that:

(a)

(1) If the county has evidence clearly demonstrating that a beneficiary is not eligible for benefits pursuant to W&IC §14005.30, but is eligible for benefits under other provisions of law, the county shall transfer the individual to the corresponding Medi-Cal program. Eligibility under W&IC §14005.30 shall continue until the transfer is complete.

(2) The CDHS shall prepare a simple, clear, consumer-friendly notice to be used by the counties, to inform beneficiaries that their Medi-Cal benefits have been transferred pursuant to paragraph (1) and to inform them about the program to which they have been transferred. To the extent feasible, the notice shall be issued with the notice of discontinuance from cash aid, and shall include all of the following:

(A) A statement that Medi-Cal benefits will continue under another program, even though aid under Chapter 2 (commencing with §11200) has been terminated.

(B) The name of the program under which benefits will continue, and an explanation of that program.

(C) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in existence for receipt of cash aid under the CalWORKs program.

(D) A statement that the Medi-Cal beneficiary does not need to fill out monthly or quarterly status reports in order to remain eligible for Medi-Cal, but shall be required to submit an annual reaffirmation form. In addition, if the person or persons to whom the notice is directed has been found eligible for transitional Medi-Cal as described in W&IC §§14005.8, 14005.81, or 14005.85, the statement shall explain the reporting requirements and duration of benefits under those programs, and shall further explain that, at the end of the duration of these benefits, a redetermination, as provided for in W&IC §14005.37 shall be conducted to determine whether benefits are available under any other provision of law.

(E) A statement describing the beneficiary's responsibility to report to the county, within 10 days, significant changes that may affect eligibility or share of cost.

(F) A telephone number to call for more information.

(G) A statement that the beneficiary's eligibility worker will not change, or, if the case has been reassigned, the new worker's name, address, and telephone number, and the hours during which the county's Medi-Cal eligibility workers can be contacted.

(W&IC §14005.32(a), to be implemented on or before July 1, 2001, per W&IC §14005.32(c))

410-17A
Senate Bill 391 amended state law and requires the California Department of Health Services (CDHS) to implement certain informing provisions in the Transitional Medi-Cal (TMC) program. These requirements include:

> A written TMC) notice must be given to CalWORKs and §1931(b) recipients at the time that Medi-Cal eligibility is established and every six months thereafter.

> The above notice and form is to be provided to recipients when they are terminated from CalWORKs or §1931(b) for failure to meet reporting requirements.

Since Assembly Bill 2730 amended the W&I Code and requires the California Department of Social Services (CDSS) to provide information on TMC and Four-Month Continuing in all Notices of Action (NOAs) messages as well as providing a flyer when CalWORKs recipients are terminated for any reason except for fraud, the CDHS TMC notice is required for those recipients.

Since Medi-Cal has dropped the status reporting requirements, the DHS TMC flyer is only required for CalWORKs and §1931(b) applicants and for §1931(b) recipients if they fail to return the annual redetermination.

(All-County Welfare Director Letter (ACWDL) No. 01-45, August 7, 2001)

410-18
State law provides as follows:

"(a) Except as provided in Section 14005.39, whenever a county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits, the county shall promptly redetermine eligibility. The procedures for redetermining Medi-Cal eligibility described in this section shall apply to all Medi-Cal beneficiaries. [Emphasis added]

"(b) Loss of eligibility for cash aid under that program shall not result in a redetermination under this section unless the reason for the loss of eligibility is one that would result in the need for a redetermination for a person whose eligibility for Medi-Cal under Section 14005.30 was determined without a concurrent determination of eligibility for cash aid under the CalWORKs program.

"(c) A loss of contact, as evidenced by the return of mail marked in such a way as to indicate that it could not be delivered to the intended recipient or that there was no forwarding address, shall require a prompt redetermination according to the procedures set forth in this section.

"(d) Except as otherwise provided in this section, Medi-Cal eligibility shall continue during the redetermination process described in this section. A Medi-Cal

beneficiary's eligibility shall not be terminated under this section until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal under any basis and due process rights guaranteed under this division have been met.

"(e) For purposes of acquiring information necessary to conduct the eligibility determinations described in subdivisions (a) to (d), inclusive, a county shall make every reasonable effort to gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility prior to contacting the beneficiary. Sources for these efforts shall include, but are not limited to, Medi-Cal, CalWORKs, and Food Stamp Program case files of the beneficiary or of any of his or her immediate family members, which are open or were closed within the last 45 days, and wherever feasible, other sources of relevant information reasonably available to the counties.

"(f) If a county cannot obtain information necessary to redetermine eligibility pursuant to subdivision (e), the county shall attempt to reach the beneficiary by telephone in order to obtain this information, either directly or in collaboration with community-based organizations so long as confidentiality is protected.

"(g) If a county's efforts pursuant to subdivisions (e) and (f) to obtain the information necessary to redetermine eligibility have failed, the county shall send to the beneficiary a form, which shall highlight the information needed to complete the eligibility determination. The county shall not request information or documentation that has been previously provided by the beneficiary, that is not absolutely necessary to complete the eligibility determination, or that is not subject to change. The form shall be accompanied by a simple, clear, consumer-friendly cover letter, which shall explain why the form is necessary, the fact that it is not necessary to be receiving CalWORKs benefits to be receiving Medi-Cal benefits, the fact that receipt of Medi-Cal benefits does not count toward any time limits imposed by the CalWORKs program, the various bases for Medi-Cal eligibility, including disability, and the fact that even persons who are employed can receive Medi-Cal benefits. The cover letter shall include a telephone number to call in order to obtain more information. The form and the cover letter shall be developed by the department in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers. A Medi-Cal beneficiary shall have no less than 20 days from the date the form is mailed pursuant to this subdivision to respond. Except as provided in subdivision (h), failure to respond prior to the end of this 20-day period shall not impact his or her Medi-Cal eligibility.

"(h) If the purpose for a redetermination under this section is a loss of contact with the Medi-Cal beneficiary, as evidenced by the return of mail marked in such a way as to indicate that it could not be delivered to the intended recipient or that there was no forwarding address, a return of the form described in subdivision (g) marked as undeliverable shall result in an immediate notice of action terminating Medi-Cal eligibility.

"(i) If, within 20 days of the date of mailing of a form to the Medi-Cal beneficiary pursuant to subdivision (g), a beneficiary does not submit the completed form to

the county, the county shall send the beneficiary a written notice of action stating that his or her eligibility shall be terminated 10 days from the date of the notice and the reasons for that determination, unless the beneficiary submits a completed form prior to the end of the 10-day period.

"(j) If, within 20 days of the date of mailing of a form to the Medi-Cal beneficiary pursuant to subdivision (g), the beneficiary submits an incomplete form, the county shall attempt to contact the beneficiary by telephone and in writing to request the necessary information. If the beneficiary does not supply the necessary information to the county within 10 days from the date the county contacts the beneficiary in regard to the complete form, a 10-day notice of termination of Medi-Cal eligibility shall be sent.

"(k) If, within 30 days of termination of a Medi-Cal beneficiary's eligibility pursuant to subdivision (h), (i), or (j), the beneficiary submits to the county a completed form, eligibility shall be determined as though the form was submitted in a timely manner and if a beneficiary is found eligible, the termination under subdivision (h), (1), or (j) shall be rescinded.

"(l) If the information reasonably available to the county pursuant to the redetermination procedures of subdivisions (d), (e), (g), and (m) does not indicate a basis of eligibility, Medi-Cal benefits may be terminated so long as due process requirements have otherwise been met."

(m) The department shall also develop a timeframe for redetermination of Medi-Cal eligibility based upon disability, including ex parte review, the redetermination form described in subdivision (g), timeframes for responding to county or state requests for additional information, and the forms and procedures to be used. The forms and procedures shall be as consumer-friendly as possible for people with disabilities. The timeframe shall provide a reasonable and adequate opportunity for the Medi-Cal beneficiary to obtain and submit medical records and other information needed to establish eligibility for Medi-Cal based upon disability.

(W&IC §14005.37(a) through (m), to be implemented on or before July 1, 2001, per W&IC §14005.37(n))

410-18A
Senate Bill (SB) 87 mandated that counties continue §1931(b) Medi-Cal eligibility for persons discontinued from CalWORKs except in those circumstances where it is clear that such persons are ineligible for §1931(b) Medi-Cal. The CDHS issued an All-County Welfare Directors Letter (ACWDL) which discussed changes in the Medi-Cal redetermination process which must be fully implemented by July 1, 2001.

CalWORKs Discontinuances

Unless there is clear evidence that there is no §1931(b) eligibility (e.g., a person has died or is in prison), the county must continue to issue Medi-Cal benefits for persons discontinued from CalWORKs. CalWORKs cases discontinued for reasons such as failure to provide essential information or the monthly income report, or failure to

cooperate with WTW requirements are not considered changes in circumstances that affect Medi-Cal eligibility. The former CalWORKs recipient should not be discontinued from Medi-Cal. Medi-Cal eligibility should be evaluated at the annual redetermination.

Thus if a CalWORKs case is approved in August 2000, and the CalWORKs case is discontinued at the end of November 2000 because the caretaker relative did not return the monthly report form, the county should continue to issue §1931(b) Medi-Cal until the annual redetermination in August 2001. If the county is aware of a change in circumstances that affects Medi-Cal eligibility before August 2001, the county may review eligibility and discontinue Medi-Cal as necessary.

Ex Parte Process

The county shall make a Medi-Cal-only eligibility determination without the involvement of the persons discontinued from CalWORKs by using the *ex parte* process when a change in circumstances affecting Medi-Cal eligibility occurs. This *ex parte* process is required in the following circumstances: failure to complete the CalWORKs annual redetermination, loss of contact/whereabouts unknown, only eligible child leaves home, change in household composition that has resulted in non-cooperation in CalWORKs evidence gathering process, excess resources, excess income and failure to cooperate with child support requirements.

When the county uses the *ex parte* process, it shall attempt to determine Medi-Cal eligibility by checking open case records, and/or case records that have been closed within the last 45 days. In addition, the county may check other resources, such as IEVS and SAVE.

When the *ex parte* process is unsuccessful in determining whether an individual is eligible for Medi-Cal, the county may contact the individual, but must document in the case record the exact reason for contacting him/her. The county shall attempt to contact the individual by telephone to request necessary information and also document all attempts to contact the individual.

When the *ex parte* process and telephone contact are unsuccessful, the county is required to send a Request for Information (the MC 355) form to the person. (ACWDL No. 01-39 discusses these requirements.)

When the individual fails to respond to the MC 355 form or does not provide sufficient information within required time frames, counties are still required to evaluate the individual for other Medi-Cal programs without the additional information/verification.

Pending Disability Determination

If the beneficiary alleges, during the *ex parte*/redetermination process, that he/she is disabled and no other basis of eligibility exists, eligibility shall continue and the county shall immediately refer the case to the Disability and Adult Program Division.

Loss of §1931(b) Eligibility

Any person discontinued from CalWORKs who is ineligible for §1931(b) Medi-Cal, or who is discontinued from §1931(b)-only Medi-Cal due to increased earnings from employment or increased child/spousal support must be evaluated for Transitional Medi-Cal (TMC) and Four-month continuing programs.

CalWORKs Denials

CalWORKs denials shall be reviewed for Medi-Cal-Only eligibility through the *ex parte* process when the applicant has completed the SAWS 2 Statement of Facts form.

(ACWDL No. 01-36, June 19, 2001)

410-18B
Senate Bill (SB) 87 mandated the California Department of Health Services (CDHS) in collaboration with counties and consumer advocates to create a request for information form which highlights the information needed to complete a Medi-Cal eligibility determination. In addition, this form is to be accompanied by a cover letter indicating the various categories of Medi-Cal eligibility. To comply with SB 87 requirements, the CDHS created the MC 355. This form serves both as a request for information and Medi-Cal informational cover letter.

Under the provisions of SB 87, counties are precluded from requesting information from a Medi-Cal beneficiary which has been previously provided, not subject to change or not absolutely necessary to complete a Medi-Cal eligibility review. All-County Welfare Directors Letter (ACWDL) No. 01-36 instructed counties to initiate a Medi-Cal eligibility review at annual redetermination and whenever there is a change in beneficiary circumstances that affects Medi-Cal eligibility. Counties were instructed to follow the ex parte process and telephone contact requirements to complete a Medi-Cal eligibility review. However, when these methods proved ineffective, counties were further instructed to notify the beneficiary through written correspondence to provide needed information in completing the eligibility review.

Effective July 1, 2001 counties are instructed to use the MC 355 as the request for information form when requesting information from a beneficiary to complete his/her Medi-Cal eligibility determination.

MC 355--Request for Information Form

A. **Description**

Front (cover letter)

> Instructs beneficiary to READ THIS SIDE FIRST.

> Lists pertinent case information completed by the county: notice date, case number, worker name/telephone number, office hours, etc.

> Explains to beneficiary why information is being requested.

> Informs beneficiary about the basic eligibility categories of the Medi-Cal program.

> Instructs the beneficiary to contact his/her eligibility worker immediately if he/she qualifies for Medi-Cal under a new or different eligibility category.

> Instructs beneficiary to contact his/her eligibility worker if there are questions or more information about this form is desired.

Back (information request)

> Highlights key eligibility categories to identify requested information. County staff shall check the appropriate box or use the OTHER category and manually write in the requested information.

> Instructs beneficiary to provide requested information by due date. County staff shall insert due date.

> Informs beneficiary to contact his/her eligibility worker if there is a change of address or telephone number.

B. **Instructions**

County staff unable to complete a Medi-Cal eligibility review through the *ex parte* process and telephone contact shall use the MC 355 to complete this review. County staff shall take the following steps:

1. Complete all necessary case information on the front of the MC 355.

2. Request only the information that is needed to complete the Medi-Cal eligibility review on the back of the MC 355. County staff shall refer to ACWDL No. 01-36 Sections "Exhausting All Avenues of Eligibility" and "Requesting Additional Information" when completing the back of the MC 355. County staff must clearly evaluate each individual and case circumstance before requesting information or verification from the beneficiary through the MC 355. County staff are reminded that the verification documentation listed on the back of the MC 355 is not all-inclusive. Therefore, county staff shall review program regulations and other correspondence (e.g., ACWDLs, ACINs, etc.) regarding further acceptable verification documentation.

3. Insert a due date for the return of the requested form and information and provide the beneficiary with a self-addressed prepaid return envelope.

C. **Processing Procedures and Timeframes**

SB 87 defines specific processing procedures and timeframes for obtaining information from all Medi-Cal beneficiaries. Therefore, the processing

procedures and timeframes described below shall also apply to the annual redetermination form (MC 210RV).

Beneficiaries shall have no less than 20 days from the date the MC 355 or MC 210RV is mailed to respond. County staff shall take one of the following actions when these forms are forwarded to the beneficiary:

1. If the requested information is not received within the 20-day timeframe, county staff shall follow current procedures to begin adequate and timely discontinuance of Medi-Cal benefits.

2. If the requested information is received incomplete within the 20-day timeframe county staff shall attempt to contact the beneficiary either by telephone or in writing to request the completed information. If the beneficiary does not comply within 10 days from the date the county contacts the beneficiary, then county staff shall follow current procedures to begin adequate and timely discontinuance of Medi-Cal benefits.

3. If the requested information is received after the Medi-Cal case is discontinued and within 30 days from the discontinuance date, then county staff shall evaluate continued Medi-Cal eligibility using the information received and rescind the discontinuance action if continued eligibility exists. Otherwise, the case shall remain discontinued.

4. If the reason for the Medi-Cal eligibility review is loss of contact and the MC 355 or MC 210RV is returned with no forwarding address and marked undeliverable, county staff shall terminate the Medi-Cal case and send an immediate discontinuance notice of action to the last known address.

(ACWDL No. 01-39, July 13, 2001)

410-18C
The Senate Bill (SB) 87 process consists of three steps. The county must follow each step until the beneficiary's continued Medi-Cal eligibility or ineligibility is accurately redetermined. The county is not permitted to substitute any step of this process with another county process or procedure.

STEP ONE

Ex Parte Review: The county evaluates all available information to establish continued Medi-Cal eligibility. If the county cannot establish continued Medi-Cal eligibility after the ex parte review, the county is required to complete Step Two. The county may use information contained in any state or county public assistance or public benefit case fle in making the ex parte determinations.

STEP TWO

Direct Contact: The county contacts the beneficiary via telephone to request information not available during the ex parte review. The county should inform the beneficiary that his/her Medi-Cal eligibility is being redetermined and more information is needed to

confirm continued eligibility. The county should further inform the beneficiary that his/her continued eligibility can be established in various ways including an allegation of disability.

If the telephone contact with the beneficiary cannot establish continued Medi-Cal eligibility and all eligibility possibilities have been exhausted, then Step Three is not required. If telephone contact with the beneficiary is not possible, then Step Three must be completed.

STEP THREE

Forwarding The Request For Information Form (MC 355). The county shall complete and send the MC 355 form to the beneficiary seeking information to establish continued Medi-Cal eligibility only if it cannot determine eligibility under Steps One and Two.

(All-County Welfare Directors Letter No. 02-59, December 23, 2002)

410-18E
A person or family who has been receiving Medi-Cal under any program other than SSI/SSP and whose eligibility is discontinued shall be evaluated by the county department to determine if Medi-Cal eligibility exists under any other program. (§50183(a))

It had been CDHS' position that when the county has determined there is no basis for continuing Medi-Cal eligibility and the beneficiary alleges disability, he/she should be advised of his/her right to apply as a disabled person. But these persons were not entitled to Medi-Cal either at zero SOC or with an SOC, pending the disability determination. (Medi-Cal Eligibility Procedures Manual §4-0-3) Since the passage of Senate Bill No. 87, aid pending is initiated, and the county must explore all avenues of eligibility before it discontinues non-disability related Medi-Cal. (Welfare & Institutions Code §§14005.31, .32, and .37, effective July 1, 2001; All-County Welfare Directors Letter No. 02-59, December 23, 2002)

410-19
State law provides that if Medi-Cal benefits may be terminated without a redetermination of eligibility when a county has facts clearly demonstrating that a Medi-Cal beneficiary cannot be eligible for Medi-Cal due to an event, such as death or change of state residency, Medi-Cal benefits shall be terminated without a redetermination under W&IC §14005.37. (W&IC §14005.39(a), to be implemented on or before July 1, 2001)

Whenever Medi-Cal eligibility is terminated without a redetermination, as provided in subdivision (a), the Medi-Cal eligibility worker shall document that fact or event causing the eligibility termination in the beneficiary's file, along with a written certification that a full redetermination could not result in a finding of Medi-Cal eligibility. Following this written certification, a notice of action specifying the basis for termination of Medi-Cal eligibility shall be sent to the beneficiary.

(W&IC §14005.39(b), to be implemented on or before July 1, 2001)

410-20
The CDHS has issued an All-County Welfare Directors Letter (ACWDL) relating to the Medi-Cal applications and maintenance of on-going Medi-Cal eligibility of individuals who are in long-term care (LTC) facilities and who are incompetent, comatose, or suffering from amnesia who do not have:

> public guardians

> conservators,

> executors, or

> spouses who are able and willing to fulfill the requirements for establishing and maintaining Medi-Cal eligibility for the individual.

PLEASE NOTE: The term "authorized representative" as used in this ACWDL in this regard relates to eligibility for Medi-Cal both at application and to maintain on-going eligibility. The purpose of this letter is NOT to affect the requirements relating to authorized representatives for the purpose of fair hearings.

(It should be noted that the policies described in this letter were rescinded, but the federal and state regulations described below still apply.)

Federal Requirements

The Code of Federal Regulations (CFR), 42 CFR §435.906 requires that individuals be permitted to apply for Medi-Cal without delay. Section 435.907 requires that the State &&require a written application" (which would include the Statement of Facts) "from the applicant, an authorized representative, or if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant." Finally, Section 435.908 states that "the agency must allow an individual or individuals of the applicant's choice to accompany, assist, and represent the applicant in the application process or a redetermination of eligibility."

Determining Competency

State regulations (§50032) define competency as "being able to act on one's own behalf in business and personal matters." The county welfare department (CWD) must determine if the LTC patient is competent to fulfill the duties required to complete the eligibility pr9cess. The eligibility worker (EW) may reach a competency decision by one of the following methods:

> Calling the LTC facility and inquiring as to the patient's ability to handle his or her own affairs.

> Obtaining a statement from the patient's physician.

> Making a "home visit" to the facility to communicate with the individual or staff.

> Obtaining satisfactory evidence from family members, which would provide the EW with sufficient reason to believe that the LTC individual is incapable of handling his or her affairs. Such evidence may include conservatorship documents or a written statement from a family member stating that the individual is unable to complete the application process without assistance.

It is important to note that if a physician's statement is presented to the CWD, that statement alone supersedes all other methods of determining competency.

An LTC Individual Is Determined To Be Incompetent

Once a CWD has determined that an LTC patient is unable to act on his/her own behalf in business and personal matters, then the applicant's spouse would be required to complete the eligibility process. If the competent spouse simply states that he or she is unwilling to participate in the Medi-Cal eligibility processes, and has a Durable Power of Attorney for the individual, he or she may use that Durable Power of Attorney to "authorize" another party to represent the applicant/beneficiary in the Medi-Cal eligibility processes.

In circumstances where the applicant has no spouse, it must be determined if the applicant has a conservator, guardian, or executor to complete the eligibility process. If the individual does have a conservator, guardian, or executor, then that person must complete the Statement of Facts.

If there is no conservator, guardian, or executor to complete the Statement of Facts, then the CWD shall determine if there is a need for protective services in accordance with §50163. If no such need is found, then the Statement of Facts "may be completed and signed on the applicant's behalf by a relative, a person who has knowledge of the applicant's circumstances, or a representative of a public agency or the county department."

The use of the disjunctive "or" in §50163 establishes that any of the named individuals may sign the Statement of Facts. The regulations do not permit the CWD to impose upon an unwilling relative the duty to become involved in the Medi-Cal eligibility processes for the incompetent LTC individual who needs Medi-Cal. Neither state nor federal regulations permit CWDs to refuse to accept applications from a person who knows of the individual's need, or forms or verification from a person who has knowledge of the person's circumstances.

Knowledge Of The Individual's Circumstances

Prior personal knowledge of the incompetent individual is irrelevant. Only knowledge of the individual's current circumstances is necessary and then relevant only for the month(s) for which eligibility is being requested. The point in time when that knowledge is obtained is also irrelevant, as long as it is obtained for completion of the Statement of Facts or when requested by the CWD and within the applicable time frames.

Anyone who acts in the best interest of the individual by obtaining this information may be considered a person who has knowledge of the individual's need to apply and of the individual's circumstances because the application process allows for a diligent search

by applicants/beneficiaries, authorized representatives, and, under the due diligence requirement, county staff to obtain information necessary to establish eligibility.

The person completing the Statement of Facts shall provide all available information required on the Statement of Facts regarding the individual's circumstances and no relevant information is to be ignored in determining eligibility. If the "authorized" representative does not have all the information necessary to make an eligibility determination, the CWD shall conduct a diligent search for the remainder.

When The Person Signing Is An Employee Of The "Authorized" Or Other Representative

The regulations specifically provide that the "authorized" or other representative can be an individual person or an organization. Section 50163 provides that, if the applicant/beneficiary is incompetent, either a relative or another individual who has knowledge of the individual's circumstances and has completed the Statement of Facts on the individual's behalf, or an attorney can be recognized as the individual's representative even without a written authorization.

Additionally, an employee who is working under the supervision of an attorney, nursing facility or other organization may be recognized as an "authorized" or other representative if the employee is working under the supervision of the attorney, nursing facility or organization which has the right to represent the individual or the spouse whether this "authorization" has been provided by family members in writing or is simply stated for inclusion in the case record.

Irresponsible Representatives

If the person acting on the behalf of an incompetent LTC individual does not cooperate with the CWID, the application should not be denied. The CWD should then proceed by completing the diligent search and determining eligibility for the individual. To deny the application and start again would delay the eligibility determination and could eliminate the individual's access to one or more months of retroactive Medi-Cal benefits.

(ACWDL No. 02-28, May 17, 2002, rescinded by ACWDL No. 02-42, July 19, 2002; 42 CFR §§435.906-.908; §§50032, 50163)